APPLICATION TO PROVIDE ADULT DAY HEALTH CARE SERVICES

The Community Long Term Care (CLTC) Program contracts with qualified providers to provide Adult Day Health Care (ADHC) services to Medicaid recipients. Case managers authorize these services. The authorization includes the days of service per week. A client-day of ADHC services consists of a minimum of five hours at the center and does not include transportation time. For individuals authorized under the Department of Disabilities and Special Needs (DDSN) waiver, the client-day may be less if the individual's condition so warrants and the provider is advised accordingly on the DDSN service authorization. Contracting as a provider of ADHC services allows the provider to serve the following groups:

- Community Choices Waiver Participants;

In addition, providers may provide services to participants in one waiver that the DDSN oversees:

- Mental Retardation/Related Disabilities Waiver Participants.

For this waiver program, DDSN will authorize services.

Any provider qualifying to provide ADHC services may also contract to provide Adult Day Health Care Nursing (ADHCN) services and Adult Day Health Care Transportation (ADHCT) services. The application form allows you to indicate if you wish to also provide those services.

Reimbursement rates are as indicated below:

- Adult Day Health Care: $45.00
- Adult Day Health Care Nursing: $15.00
- Adult Day Health Care Transportation: $15.00

Providers must follow the Scopes of Services for each of these services, as well as meeting all other contractual obligations. The Scope of Services can be found on this web site. You should print a copy to review before completing this application.

Each Participant is required to choose a provider from a CLIENT CHOICE OF PROVIDER FORM that lists all CLTC providers in the area by county. Because of the Participant choice of provider policy we cannot guarantee the number of CLTC Participants any provider will be authorized to serve. Therefore, we urge all providers not to rely upon Medicaid as the primary source for reimbursement. **Business decisions should not be made based on any agency's or individual's anticipation of receiving any referrals from CLTC**.

In order to complete an application, print this document. Check the appropriate boxes and fill in the information that is requested. You must also include the items listed in addition to completing this application.

Applications should be sent to: **Division of Community Long Term Care- Waiver Management, Post Office Box 8206, Columbia, SC 29202-8206, Attention: Chaini Demas**. If you have any questions regarding this process or the stated requirements, please call Chaini Demas at (803) 898-2709 or Tony Matthews at (803) 898-2712.

If you contract for the Adult Day Health Care Nursing, you will be required to apply for a National Provider Identifier (NPI). You can apply for an NPI by calling (800) 465-3203 or (800) 692-2326 (TTY) or by visiting the website at https://nppes.cms.hhs.gov

The following items must be checked and/or enclosed for this application to be considered for processing:

I wish to become a provider of the following services: (Check all for which you are applying)

- ❑ Adult Day Care
- ❑ Adult Day Care Nursing
- ❑ Adult Day Care Transportation

❑ I understand that It will be necessary to schedule a DHHS pre-contractual review visit as part of the contracting process and that I will be contacted prior to this visit.

❑ I agree to abide by all requirements and policies of the Department of Health and Human Services as described in the contract and any other communication received from DHHS.

❑ I certify that neither I, nor any officer, director, administrator, billing agent, managing employee, affiliated person or partner, or shareholder having an ownership interest has been involuntarily terminated or has involuntarily withdrawn from participation in the CLTC Program within the last three (3) years.

❑ By checking this box I am indicating that my agency requires Medicaid participants to sign agreements. I understand that I must include copies of all agreements with this provider application.

❑ I certify that this agency will submit any subcontracts to DHHS for prior approval.

❑ My regularly scheduled holidays are listed on the attached sheet.

❑ The county or counties in which my agency plans to provide services are listed on the attached sheet:

❑ I understand that this agency may be reviewed by DHHS at any time during normal business hours. This review can be announced or unannounced. I also understand that my agency must produce all requested records related to the administration of the agency, staff records and individual client records.

❑ I understand that persons providing ADHC and ADHCN services must use the Care Call system to document their service delivery and adherence to this contract.

❑ I understand that I must abide by all marketing limitations as indicated in the contract.

❑ I understand that I must not give any type of gifts, samples or other products to CLTC case managers, DDSN service coordinators or other CLTC/DDSN employees.

❑ I understand that my staff must report incidents of abuse, neglect or exploitation of adult beneficiaries in accordance with the Omnibus Adult Protection Act (S.C. Code of Laws Section 43-35-5, et seq.).

❑ I understand that I must have a current licensure from the SC Department of Health and Environmental Control.

❑ I understand that I will be required to attend a training session at SCDHHS prior to the initiation of a contract.

The name of the person who will sign the contract: _____

The name of the person designated to serve as the agency administrator: _____

The following items must be submitted with your application:

- Copies of current licenses of all nurses working with your agency.
- You must submit certified evidence of not less than $10,000.00 operating capital that will show that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. This must be a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included.
- Documentation that demonstrates experience, i.e., written references, established agency verification, etc., in providing ADHC or a similar service.
- A copy of your organizational chart that includes the names of persons in any management or ownership capacity. (See attached form)
- A copy of the provider agency's Workers' Compensation Insurance Policy. If you do not yet have one, please indicate on your application. A copy of the policy must be presented prior to the provision of services.
- A copy or letter of certification of the provider agency's current liability insurance Policy showing coverage to include date of application.
- A copy of your articles of incorporation or other document that established you as a legal entity. If you do not already have this, it must be obtained from the Secretary of State. If you are a Sole Proprietor, this is not required. Sole Proprietors must provide a copy of your business license.
- A copy of your Employer Identification Number (EIN) confirmation letter.
- A completed Pre-contractual Information Form. (See attached form)
- A copy of your current DHEC licensure for Adult Day Care Facility

The following items must be brought to your scheduled training session:

- Mock employee and participant chart
- Infectious disease program

I certify that all information given with this application is true. I understand that any false information will result in this application being denied.

_____ _____ _____

Applicant's signature **Title** **Date**

_____

Applicant's Name Printed

Agency Telephone Number_____

Alternate Telephone Number_____

Agency Fax Number_____

Agency name _____

Agency physical address _____

_____

_____

Agency mailing address if different than physical address

_____

_____

Email address: _____

List of Scheduled Holidays

Check each holiday observed by your agency and indicate additional holidays below.

- ❑ New Year's Day
- ❑ Martin Luther King's Birthday
- ❑ Presidents Day
- ❑ Good Friday
- ❑ Easter
- ❑ Memorial Day
- ❑ Independence Day (July 4th or day observed)
- ❑ Labor Day
- ❑ Veterans Day
- ❑ Thanksgiving
- ❑ Day after Thanksgiving
- ❑ Christmas Eve
- ❑ Christmas
- ❑ Day after Christmas

List additional holidays here:

_____

_____

Counties Served

Put a check next to every county in which you intend to provide services.

- ☐ Abbeville
- ☐ Aiken
- ☐ Allendale
- ☐ Anderson
- ☐ Bamberg
- ☐ Barnwell
- ☐ Beaufort
- ☐ Berkeley
- ☐ Calhoun
- ☐ Charleston
- ☐ Cherokee
- ☐ Chester
- ☐ Chesterfield
- ☐ Clarendon
- ☐ Colleton
- ☐ Darlington
- ☐ Dillon
- ☐ Dorchester
- ☐ Edgefield
- ☐ Fairfield
- ☐ Florence
- ☐ Georgetown
- ☐ Greenville
- ☐ Greenwood
- ☐ Hampton
- ☐ Horry
- ☐ Jasper
- ☐ Kershaw
- ☐ Lancaster
- ☐ Laurens
- ☐ Lee
- ☐ Lexington
- ☐ McCormick
- ☐ Marion
- ☐ Marlboro
- ☐ Newberry
- ☐ Oconee
- ☐ Orangeburg
- ☐ Pickens
- ☐ Richland
- ☐ Saluda
- ☐ Spartanburg
- ☐ Sumter
- ☐ Union
- ☐ Williamsburg
- ☐ York
- ☐ Statewide

Pre-Contractual Information Form

Have you ever worked for an agency that has received Medicaid funds? _____

If yes, what agency and what was your position? _____

_____

Have you have ever been an enrolled or contracted Medicaid provider?
If yes, when (dates)_____ Which state? _____ What service did you provide?_____
What was/is your previous/current Medicaid provider number?_____
Are you currently enrolled or contracted with DHHS for any service provision? _____
If not, when did contract or enrollment end?_____
If terminated, was termination voluntary or involuntary?_____
If this is an agency or corporate entity, has the agency ever been enrolled or contracted with Medicaid? If yes, when? (dates)_____ Which state?_____
What type of service was provided?_____

_____

What was/is the agency's or corporate entity's previous/current Medicaid provider number?_____

Have any officers, agents or employees been terminated, been denied participation in the Medicaid Program or denied a contract with DHHS?_____
If yes, when? (dates) _____ For what service? _____
Reason?

_____

Any falsification of information submitted is grounds for denial or termination of a contract.

_____ _____
Signature Date

SAMPLE ORGANIZATIONAL CHART

President

Name:_____

Chief Executive Officer

Name:_____

Chief Financial Officer

Name:_____

Chief Operations Officer

Name:_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

*This chart is only a sample and may not apply to the organizational structure of your company. You may utilize this chart or create your own that more closely represents the organizational structure of your company.